CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555773	A. BUILDING _____ B. WING _____	04/24/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKY HARBOR CARE CENTER	57333 JOSHUA LANE, YUCCA VALLEY, CA 92284 SAN BERNARDINO COUNTY

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	The following reflects the findings of the Department of Public Health during a Complaint Investigation visit. Representing the Department of Public Health: [redacted] CLASS AA CITATION -- PATIENT CARE 24-2042-0004394-S Complaint(s): CA00112528 72311(a)(2) Nursing Services General (a)Nursing service shall include, but not be limited to, the following: (2)Implementing of each patient's care plans according to the methods indicated. Each patient's care shall be based on this plan. Based on interview, and record review it was determined that the facility failed to implement Patient 1's care plan according to the methods indicated when transferring Patient 1 as evidenced by only one person having performed the transfer without the required gait belt. Failure to correctly implement Patient 1's care plan resulted in the patient being dropped on knees by CNA 1 which caused fractures in both thigh bones requiring surgery that later contributed in her death on April 18, 2007. On April 23, 2007, record review reflected Patient 1, a 86 year old female, who was originally admitted to the facility on January 2, 2003 and readmitted on November 17, 2006 with diagnoses that included pneumonia, chronic obstructive pulmonary disease (COPD), coronary artery disease, hypertension (high blood pressure), renal failure, osteoarthritis (arthritis affecting the bone joints), and diabetes that required			

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	Continued From page 1 insulin shots. On same day, review of the completed Minimum Data Set (MDS) with assessment date of February 16, 2007 indicated Patient 1 had short term and long term memory problems; and, when making decisions, she needed supervision and/or cues because she had poor decision-making skills. The same MDS indicated Patient 1 depended on facility staff for all activities of daily living (for example moving in bed, dressing, and eating), and needed two plus persons to assist with transfers. During an interview with the Director of Nursing (DON), on April 23, 2007, at 1:10 p.m., she stated on April 13, 2007 CNA 1 had Patient 1 stand up so she could pull up Patient 1's pants. Review of Patient 1's clinical record on April 23, 2007 revealed care plans that showed Patient 1 was at risk for falls and had a self care deficit. Both care plans indicated Patient 1 required two persons and a gait belt (a belt that is secured around the patient's waist that provides a secure and safe hand hold for staff) when being transferred. The Nurses Progress Notes dated April 13, 2007, at 4 p.m. indicated Patient 1 fell on the floor during a transfer by CNA 1. Patient 1 complained of knee pain. Staff documented at 7 p.m., Patient 1 was given medicine for her knee pain. The Nurses Progress Notes for 4/14/07 indicated Patient 1 moaned when she was moved and was given medication for the pain. Staff documented blood			

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	Continued From page 2 pressure was 84/44 (low for Patient 1), face was pale, and staff called for an ambulance. On April 14, 2007, at 10:25 a.m., Patient 1 was transported by ambulance to an acute care hospital. Review of Patient 1's clinical record from the acute care hospital on April 24, 2007 revealed that Patient 1 presented to the emergency room on April 14, 2007, at 11:24 a.m., complaining of severe pain in the right and left knees. Under Clinical Impression, the emergency room physician documented right distal femur (thigh bone) fracture (break in the right leg bone just above the knee), left distal femur (thigh bone) fracture (break in the left leg bone just above the knee), and anemia (likely due to blood loss in legs) On April 15, 2007 at 3:18 a.m., Patient 1 was transferred to another acute care hospital because she needed a higher level of care. Consultation documented by the Orthopedic Physician reflected the following: "The lower extremity fractures are painful and make nursing care difficult.; ...this lady's prognosis is very poor..."; and "The option to do nothing, put her in hospice (program used when death is imminent), give pain medication and expect more rapid demise." or surgery "either way her prognosis is poor." The same consultation document revealed the femoral neck had a displaced fracture (the two ends of broken bone are separated from one another). Surgery would include internal fixation of the left hip fracture with screws, fixation of left femoral fracture with a flexible nail (a metal nail inserted down the			

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	Continued From page 3			

middle of the leg bone), and closed reduction (move bone back into place without making an incision) of right femur with splinting.

Review of the Operative Report showed that the surgical procedure as stated above was done, under general anesthesia, on April 16, 2007.

Two days later on April 18, 2007 at 8:10 p.m., Patient 1 died.

Review of the death certificate dated June 29, 2007 listed the immediate cause of death as "hypertensive and atherosclerotic cardiovascular disease" with other significant conditions contributing to death as "bilateral hip and femur fractures." Date of death documented as April 18, 2007.

Facility staff failed to implement Patient 1's care plans for transferring with two persons and use of gait belt.

Patient 1 fell to the floor on her knees which resulted in fractures of both legs.

Patient 1 underwent surgery on April 16, 2007 and subsequently died two days later from complications from the leg fractures.

These violations presented either imminent danger that death or serious harm would result or a substantial probability that death or serious physical harm would result and was a direct proximate cause of the death of the patient.

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